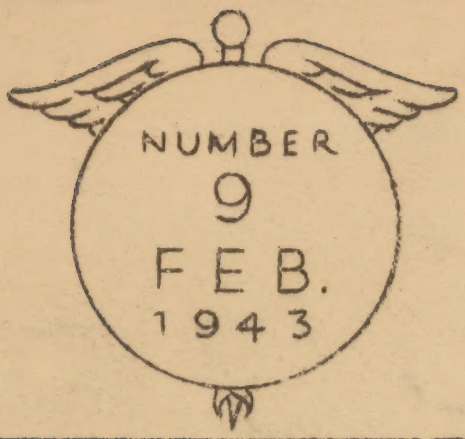

MONTHLY BULLETIN

OFFICE OF THE CHIEF SURGEON USASOS, SWPA

F-O-R-E-W-O-R-D

The Monthly Bulletin - Office of the Chief Surgeon, U.S.A. S.O.S., S.W.P.A., is published for the purpose of disseminating information of general interest and of administrative value to the Medical Department personnel of the United States Army forces in S.W.P.A.

All Medical Department officers and agencies are invited to submit items of general interest for future publication. It is not intended that the material herein contained shall have the force of directives (except where directives are quoted) but should be used as a guide by those concerned.

N-O-T-E

The Chief Surgeon requests that the Commanding Officer of each unit make such arrangements as are necessary to ensure that every commissioned officer in his organization reads this bulletin each month.

ADMINISTRATIVE SECTION

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1.- Unauthorized Statements:- Information has reached this headquarters that medical officers are making verbal statements to officers of other branches to the effect that they should not serve in, or be returned to, a tropical climate.

It is requested that this practice be stopped immediately. The decision as to physical fitness of any officer to perform full duty will be made only by a board of medical officers at a U.S. Army General Hospital.

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2.- Australian Patients in U.S. Army Hospitals:- The Officer of Records of the Australian Army has requested, in the event of Australian personnel being admitted to U.S. Army hospitals, such hospitals render returns, at least weekly, of the date of all Australian admissions to hospital, diagnosis, and when discharged / or where transferred, to the Office of Records in the respective L. of C. Area.

For your information, Australian Officers of Records are located as follows:-

Queensland L. of C. Area (Includes N. G. Force)	Brisbane
New South Wales L. of C. Area	Sydney
Victoria " "	Melbourne
South Australia " "	Adelaide
West Australia " "	Perth
Tasmania " "	Hobart
Northern Territory Force No. 14 L. of C. Area	Darwin.

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3.- Battle Casualties and Progress Reports:- Attention is invited to Sec. 11 USASOS Memo. No. 17, January 1943 quoted below:-

1. Psychoneurosis or other mental disease developing under battle conditions (commonly, but improperly, designated as "battle neurosis", "hysteria","shell shock" etc.) will not be classified as "battle casualties" or reported as "wounded in action".

2. When it is found that cases have been erroneously reported as battle casualties a corrected report will be sent immediately by radio or safe hand air courier to the Commanding General, USASOS.

3. When a WIA case has finished treatment for WIA condition but is retained in hospital for other treatment, he will be dropped from WIA list by reporting to this Headquarters on "Progress Reports WIA Cases" under Code "E" but giving diagnosis for which he is being held in hospital.

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4.- Medical Attendance for Civilian Employees of War Department on Foreign Military Missions:- Under the provisions of W.D. Circular 373, November 13, 1942, civilian employees of the War Department on Military missions abroad, will be admitted without cost to themselves, except for subsistence, to Army Hospitals and other medical installations, for care and treatment, whenever necessary, until completion of their foreign missions.

Subsistence rates will be charged as follows:-

For civilians on enlisted men status .. .. 5/- per day
For civilians on Officer status .. .. .. 5/6 per day

The Commanding Officer of the hospital will determine the status upon which subsistence charges will be based. Collection of charges will be made by the hospital at the time patient is discharged.

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5.- Hospital administration and professional service: Attention is invited to S.G.O. Circular Letter No. 148 dated November 9, 1942 which reads as follows:-

1. It is essential to the efficiency of hospital operations that patients be disposed of as promptly as is consistent with sound professional and administrative procedure. Delay beyond this point results in lost man-days, increased hospitalization costs, crowded hospitals, and poor patient morale. The records of certain hospitals, with regard to this point, indicate that current performance can be improved greatly.

2. Voluminous hospital records frequently result from "padding" by repetition, verbosity, and the inclusion of extraneous historical material and forms. While accuracy and completeness are essential, judgment and effort should be exercised to the end of attaining brevity and compactness in hospital records.

3. In certain hospitals requests for unnecessary laboratory examinations appear to be routine. Overloading, by irrelevant routine, and repetitive requests, invariably leads to deterioration of the high standard of laboratory performance which is essential to good hospital service. Judgment and discretion in the use of the laboratory are necessary and afford an index of the clinical acumen of the professional staff.

4. The attention of hospital commanders is directed to these important matters. Corrective measures will be instituted promptly wherever indicated.

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6.- Statement of the Hospital Fund:- In order to avoid gains or losses on the Statement of the Hospital Fund all transactions will be made in Australian Currency. Therefore, in preparing mess bills for individuals required to pay for their own subsistence, the ration value will be shown in Australian Currency, eliminating all reference to U.S. Currency, for example, in rendering a mess bill for 10 rations at $1.00 per ration, the proper entry on the mess bill would be 10 rations at 6/2d. per

ration - £3. 1. 8. Likewise, in rendering a mess bill for 10 rations at 70¢ per ration, the proper entry on the mess bill would be 10 rations at 4/4d. - £2. 3. 4.

All financial transactions shown on Statements of the Hospital Fund rendered to this headquarters will be computed and recorded exclusively in Australian Currency.

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7.- Help Get More Mileage Per Glove:- Many miles can be added to tires by proper care and attention, and the same is true of all rubber products, especially so with the thin rubber glove of the surgeon.

Surgeons gloves are made from thin rubber or latex products and require the finest of East Indian rubber in their manufacture. Thin rubber gloves of proper resilience must be supplied to the surgeon for his and the patient's protection, since the operator must maintain his "touch". The source of this type of rubber has been cut off, and the supply available in this country is strictly limited.

Gloves should be autoclaved under the direction of a single trained individual and should not be the responsibility of several nurses. Rubber gloves absorb moisture during autoclaving, and packs should be allowed to cool on an absorbent material, neither metal nor glass. Autoclaved gloves should not be reissued the same day.

In preparing the glove pack for sterilization, the pack should be folded loosely without folding the gloves and a single row of packs placed along the edge of an instrument or special tray without compressing. A gauze pad or powder pack should be placed inside the turned back cuff to aid the steam in reaching all surfaces.

Gloves should always be sterilized by themselves under specific instructions for gloves, and not in conjunction with other items. A temperature of 248-250 degrees F. for not more than 15 minutes is recommended where gloves are packed and charged properly. Temperature readings should be taken from the discharge line; exhaust all air from the autoclave.

Pasteboard controls are not satisfactory for gloves: a recording thermometer should be used.

One sure sign of oversterilization of gloves is "stickiness", which may also indicate contact with some material that dissolves rubber. Gloves should never be "dried" in sunlight, and any contact with greasy or oxidizing agents should be avoided.

Old gloves should be used for the repair of those which have been punctured by needles or those which are only slightly torn. Small patches can be made from these old gloves, rubber cement being all that is needed to make a tight repair. Punctured gloves should not be thrown away.

Finally, dust the user's hands thoroughly with talc and caution him or her to be gentle in pulling on gloves. It is

true that improper sterilization and drying greatly weakens the rubber fabric, but a real hard "pull" often puts the fingers right through the glove, and this corresponds exactly to a "blowout" on your car.

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8.- Assignment of Limited Service Personnel:- From time to time enlisted men who have been placed on limited service may be available for assignment to a hospital or to headquarters of various medical installations.

Requests for limited service men should be submitted, through channels, to the Commanding Officer of the Base Section. If a particular man is desired, name, rank, and serial number should be given together with reasons for the request. If no particular man is desired the request should state number of men desired and specification serial number.

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9.- A New AR 40-100:- "Standards of Miscellaneous Physical Examination" dated Nov. 16, 1942 has been distributed throughout this area during the past month. Attention is directed especially to changes in standards for applicants for officer candidate schools (paragraph 10).

A new paragraph (15) has been added on "Limited Service; officers, Army nurses, and warrant officers of Reserve components for extended active duty and original appointment of other than graduates of officers candidate schools."

Medical examiners conducting physical examinations of individuals for appointment as officers, Army nurses, or warrant officers, should familiarize themselves with the provisions of this new regulation.

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10.- Official address of this Office:- Much delay and confusion is occasioned by misaddressing mail intended for delivery to the Office of the Chief Surgeon. For information and to prevent re-occurence the official address of this office is:-

The Chief Surgeon,
Headquarters, USASOS,
A.P.O. 501.

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11.- Victory Tax:- The following information is published for the guidance of all concerned in obligating and expending M. & H.D. Funds regarding Victory Tax.

The Revenue Act of 1942 requires a withholding of 5% of all earnings, inclusive of allowances , effective 1 January, 1943, and is called Victory Tax. This tax applies not only to all military personnel but to all United States Citizen - civilian employees earning in excess of $624.00 per annum. In a pay

period beginning after 31 December, 1942 and being paid in January, 1943, a Victory Tax deduction must be made from all compensation earned during that period. There will be no Victory Tax withheld on any compersation wholly earned on or before 31 December, 1942, but paid thereafter.

The wages earned in two calendar years are taxable in the calendar year in which the pay period ends, e.g. quarterly, 1 December, 1941 to 28 February, 1942, and semi-annually, 1 July, 1942, to 30 June, 1943. Errors may be explained on the payroll of a subsequent quarter, pertaining to the previous quarter in which the Tax was withheld.

Civilian payrolls will have a column headed "Victory Tax". In the signature column, the certifying officer will state that there is a 5% deduction on any salaries in excess of $624.00. The withholding rate is 5% of salaries or wages in excess of withholding deductions. The 5% tax will be obligated and expended against M. & H.D. Funds under the same procedure as now in effect for retirement deductions.

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12.- Changes in Army Regulations 40-1080:- Attention is invited to the following changes in paragraphs 4 and 5 of AR 40-1080 dated December 31, 1942

4. Special reports of acute communicable diseases prevailing at stations when troops are transferred. When troops aretrans-ferred from one station to another, the commanding officer of the station from which the troops are departing will report by telegraph, or other similar means, to the commanding officer of the new station the acute communicable diseases which are currently prevalent to a significant degree at his station.

5. Reports of acute communicable diseases occuring among troops en route. Should acute communicable diseases occur in a unit or detachment en route to a new station, the senior officer accompanying the troops will report the nature and extent of the outbreak by telegraph, or other similar means, to the commanding officer of the station or command to which the troops are en route. Should no officer accompany the troops changing station, the enlisted man in charge will likewise report such information as he may be able to obtain.

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13.- Admission of Casuals to Hospitals:- When Australian and American personnel are admitted to a hospital as casuals, a written report will be made immediately to the Commanding Officer of their organizations giving all facts in the cases. If line of duty status is in doubt the necessary investigation will be made, in accordance with AR 345-415.

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PROFESSIONAL SECTION

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VENEREAL DISEASE

Prepared by Lt. Col. Ivy A. Pelzman, M.C.
Venereal Disease Control Officer, Office of the Chief Surgeon.

Mimeographed copies of Venereal Disease Section of A.R. 40-210 W.D., September 15, 1942 have been furnished to all medical units in the area. In order to comply with that portion of changes referring to initiation and forwarding syphilis registers, a new notification form has been prepared, and it is recommended that this form be used not only for all new registers that are initiated, but that they be likewise completed and forwarded to custodians of soldiers' service records of individuals currently under syphilitic treatment. It is felt that compliance with the provisions of this new regulation, and the prompt forwarding of the above noted new form, will eliminate many lapses of syphilitic treatments previously caused when personnel under treatment were transferred to new stations.

Medical officers should be constantly on the alert to see that all men under syphilitic treatment be regular in their attendance, and that in the event of absence from treatment, that the unit commander be promptly notified.

Attention is invited to the Venereal Disease section in A.R. 40-210 Paragraph 23 d 2 wherein there is a radical change as to the time when instruction in sex hygiene will be provided for enlisted men.

It is recommended that personnel be advised as to the availability of serological test facilities and that those who have been promiscuous should take advantage of these tests at regular intervals.

All medical officers should redouble their efforts in supervising Venereal Disease control in staging areas, leave camps and cities where personnel are visiting on furloughs. This likewise applies to all hospital units in which ambulatory patients are given passes. Men going on furloughs or passes should be furnished with an ample supply of prophylactic materials, and should likewise be informed as to locations of prophylactic stations in nearby cities.

In order to maintain effective strength of organizations, under the provisions of Circular Letter No. 74, S.G.O., unit surgeons may consider the advisability of giving treatment of venereal disease cases on a duty status with their organization while in the combat zone.

Instances have been occurring wherein soldiers have reported to medical officers with history of syphilitic treatment prior to entry into the service, also since entry into the service with no syphilitic register accompanying soldiers records. The following procedure is recommended in such cases:-

a. As soon as possible the soldier should be admitted into a hospital for a complete examination, including Fluroscopic, X-Ray, serological and spinal fluid tests. Every effort should be made to make a proper diagnostic classification of the case. In the event that repeated serological tests are negative, the case cannot be classified as a latent one, but the proper diagnostic nomenclature would be "syphilis, type undetermined".

b. The syphilitic register should be started, and included therein would be a very careful history of the original infection, and a resume of soldier's statement as to amount and approximate dates of treatment previously given.

c. The period of hospitalization ordinarily need not be prolonged more than two or three days, and treatment should be continued by unit medical officers.

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HOSPITALIZATION - PROGRESS

Prepared by Lt Cd.L. R. Custer, M.C.,
Chief of Hospitalization.

The Office of the Chief Engineer , in collaboration with the Office of the Chief Surgeon, has developed types of prefabricated structures which may be used advantageously for purposes of hospitalization. One type has been designed, which may be used for ware-houses, hospital wards, and similar structures, and another has been designed, more elaborate in detail, which may be used to provide the facilities in hospitals for special services. It is planned that these prefabricated structures shall enter more and more into the hospital picture for this area. The better type of structure mentioned above, was developed as a prefabricated, demountable, infirmary which permitted all the functions of an infirmary, with an 8-bed ward attached. The plumbing and all utilities are likewise prefabricated and demountable. The result is that this infirmary, complete and ready for function, may be set up in 100 man hours , i.e. 10 men can completely establish the infirmary in 10 hours, and it may be demounted and moved to a new location if necessary.

All types of prefabricated structures have been investigated thoroughly, and those selected for our purposes are being manufactures on a large scale. They will be of particular value in the establishment of 50 and 100 bed hospitals in isolated areas, or where the tactical situation varies.

Standard A/TO plans for this area are now practically complete and final in character. A sufficient amount of construction has been done so that the adequacy of the planned construction can be determined. As a result, completely standardised plans, which will seldom be altered, are now being grouped together. It is planned that in subsequent months alterations and improvements will be gathered together and intered at one time.

A group of hospitals is being developed with all central features, such as the central laboratory, base dental laboratory, physiotherapy department, and other central facilities which will permit the development of a hospital center.

VENOMOUS VERTEBRATES

Prepared by Capt. Henry B. Gwynn, M.C.
Medical Consultant, Office of the Chief Surgeon.

STONE FISH:- This fish lies on the bottom of pools and has prominent dorsal spines through which venom flows when contact is established. The venom is very much like curare, causing collapse and occasionally death. This should be treated as snake bites, and Morphine is often required because of severe pain.

SNAKES*:- There are a great number of varieties of snakes in Australia. However, for practical purposes the most important are:-

Boa Constrictors
Tiger Snakes
Death Adders
Brown Snakes
Copper Heads
Black Snakes.

The Tiger snake is probably the most improtant snake that we have to deal with as it will attack on the least provocation. The Death Adder is slightly more venomous, but only attacks on provocation. The Boa Constrictor is a non-venomous snake, but kills by constriction; nevertheless its bites are serious because they are apt to be very septic, therefore, sulfadiagine should be given to persons bitten by this snake. Generally speaking the predominant action of Australian snake venoms is neurotoxic, partly central and partly peripheral. The extent to which the neurotoxic action is developed determines the toxicity of the Australian venoms. The secondary group of actions is linked up with their haemolytic and cytolytic powers. The third action of these venoms is coagulant and depends upon the conversion of prothrombin to thrombin.

There are a great many factors which determine the danger of a snake bite to an individual, such as, type of snake, location of bite (rarely the venom may find its way to a vein to cause rapid death), the size of the snake, the nature of the bite (whether a "snap" bite or prolonged bite), amount of clothing penetrated, and previous history of the snake (whether it has bitten some other object recently).

SYMPTOMS:- Early symptoms generally occur 15 minutes to 2 hours after a bite and are, nausea, vomiting, faintness, and drowsiness. The patient of course is in a state of shock. If neurotoxic symptoms are predominent the gait is incordinate, sensation is blunted, the pupils are dilated and react neither to light nor accommodation. The respiration becomes slow and the patient passes into coma. Laboratory examination frequently shows albuminuria and hematuria.

* Abstracted from The Medical Journal of Australia, Aug. 29, 1942 - "The Symptomatology and Treatment of the Bites of Australian Snakes" by Col. C. H. Kellaway.

TREATMENT:- 1. The first stage in the treatment of snake bite is the immediate application of a tourniquet if the bite is located on a limb. This delays the entry of venom into the circulation and affords time for other treatment. This tourniq may be left in position for at least 2 hours. After 30 minu release the tourniquet for approximately ½ minute and then each succeeding 10 minutes release the tourniquet for increasing intervals as determined by the patient's symptoms.

2. The surface of a bite should be washed with clean water.

3. The bite should be excised if the bitten person is seen at once and should include all the tissues to the depth of the fang puncture which is approximately ¼ inch. In cases in which only incision is used, suction by mouth or by dry cupping shoul be done.

4. If an efficient tourniquet has been applied immediately after the bite, local venesection may be performed by applying a venous tourniquet distal to the arterial tourniquet. This will allow bleeding to occur from the vein, thereby washing out the affected area when the arterial tourniquet is released which should be done many times.

5. A Monovalent Antivenene is prepared by the Commonwealth Serum Laboratories in ampules containing 5-7cc(1,500 units) of antivenene which is effective against most Australian snakes with the exception of the Death Adder and Brown snakes. In the case of the Tiger snake 2 ampules (3,000 units) should be given as soon as possible intravenously. These patients should be tested for serum reactions first.

6. The general treatment is to keep the patient at rest, warm, and supplied with fluids. Alcohol is of no value and, infact, may be distinctly harmful. Morphine is likewise contra indicated. On the other hand Caffeine is useful in stimulating the central nervous system. It should be pointed out that a patient may apparently be making a good recovery from a snake bite but suddenly die of respiratory failure 4 hours later. Therefore do not relax the treatment or let the patient move around until all danger is over.

Venomous Plants.

STINGING TREE:- A tree known as the stinging tree from 30 to 40 feet in height grows on the edge of the scrub in North Queensland and New Guinea. Contact with this tree causes release of Formic Acid, creating an intense stinging sensation which may at times even require the use of Morphine to alleviate.

Venomous Invertebrates.

JELLY FISH:- A good example of this species is the venomo Portugese Man of War. These fish have cells in their tentacles which contain a barbed spring which, upon release into the flesh, liberates an acid. This can cause severe collapse. The best treatment is to use an alkaline wash locally and sedatives orally.

ATHRAS:- This is a form of spider which lives in scrubby country and digs holes in the ground. It displays a lot of fight and upon biting emits a venom. This has caused fatalities, and the treatment is the same as of snake bite.

RED BACK BLACK SPIDER:- This is similar to the American Black Widow Spider, but has a red dot on back. This is widely distributed in SWPA. It generally bites only when sat upon and has cuased fatalities in children. Even in adults it causes great pain followed by profound collapse. The treatment is the same as of snake bite.

SCORPIONS:- These are present in this area but are not very venomous and cause mainly a local effect.

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TREATMENT OF TRICHOPHYTOSIS OF THE FEET AND GROIN

Prepared by Capt. L. Katzenstein, M.C.
Dermatologist, 118th General Hospital.

Recent examples of over-treatment of trichophytosis of the feet and groin, with a subsequent contact dermatitis, suggest the need of stating a plan for the treatment of this disease. The principles are aptly noted by Lieut. Colonel C. F. Lehmann, M.C., in his article entitled, "Dermatology in the Army", in the Aug 29 1942 issue of the Jour. A.M.A:

> "The treatment of infections of the feet is most satisfactorily accomplished by more attention to certain principles of treatment and less to any particular medicament. These demand treatment of the skin rather than of the primary disease. These principles are: 1) Allaying the inflammation before resorting to stronger fungicides -- in other words, not irritating an already inflamed skin with strong chemicals; 2) rest -- the response to treatment is greatly accelerated by avoidance of weight-bearing and rubbing of the infected skin; 3) use of keratolytic agents when the skin is ready for them; and 4) prevention of early recurrences by sterilization of shoes and use of foot powders."

1. Allaying the inflammation: When the skin of the feet is red, vesiculated, macerated, secondarily infected, or superficially ulcerated, keratolytics such as Whitfield's Ointment must not be used. The lesion should be treated as an acute dermatitis. Potassium permanganate solution, 1:4000, or saturated solution of boric acid, as a soak or compress, should be applied for 2 to 3 hours daily. Between applications the skin should be covered with calamine lotion. Sulfonamides in crystalline or ointment form should be used only in the treatment of secondary infection. They have little value in the treatment of the trichophytosis. And they must be used cautiously, for they may produce a local dermatitis, increase the severity of a pre-existent dermatitis, or cause a generalized dermatitis in a sensitive individual.

2. Rest: As the inflammation subsides, Lassar's paste may be substituted for the calamine lotion. During the acute and subacute stages, fractional x-ray therapy of 70 Roentgens weekly is very helpful. Ultraviolet radiation is of no use. Rest is a valuable aid. Bullae and pustules should be incised only. Soap and water is avoided. The lotion or paste is gently removed before each soak so that the solution is in close contact with the skin.

3. Use of keratolytic agents when the skin is ready for them: When the redness, vesiculation, maceration, secondary infection and superficial ulceration have healed, one-quarter strength Whitfield's Ointment is used between the soaks. If it causes any irritation, subjective or objective, it must be immediately discontinued and the bland therapy continued for a longer period. If it is used for several days without difficulty it may be increased to one-half strength. Full-strength Whitfield Ointment is used only on hyperkeratotic lesions. Meanwhile, the soaks are diminished to 1 or 2 hours daily.

4. Follow-up treatment: G1 foot powder should be applied liberally during the day. One-half strength Whitfield's Ointment is used at night until all the white infected skin is replaced by normal pink skin. The soldier should be cautioned to remove his shoes and socks and dry his feet carefully whenever he is at rest, for perspiration is the spark that ignites the flame of trichophytosis in everyone susceptible to it.

The treatment of trichophytosis of the groin is exactly the same as that of the feet. The same rules for the care of the dermatitis must be observed. However, when the stage is reached when a keratolytic is indicated in a few individuals, Whitfield's Ointment may cause irritation because of an ointment being used on the closely approximated surfaces of the groin. In these persons, Castellanni's solution of 5 per cent salicylic acid in 50 per cent alcohol, may be substituted. As trichophytosis of the groin is frequently metastatic from the feet, even mild fungus lesions of the feet must be carefully treated to prevent relapse in the groin.

The allergic vesicular eruption of the hands, trichophytids, need be treated with bland therapy alone. No keratolytics are used on the hands. When the feet are cleared of the fungus infection, the hands will heal quickly.

The treatment of trichophytosis complicated by eczematization or secondary infection, or both, takes several weeks. There are no short cuts. The use of cauterizing agents such as iodine, silver nitrate, or phenol, is often harmful. Changing from one medication to another in an effort to produce a quick cure will usually result in a dermatitis of increased severity. "The treatment of the skin rather than the primary disease" will reduce by many weeks the time spent in the therapy of trichophytosis.

DENTAL SECTION

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DENTAL STANDARDS FOR PHYSICAL EXAMINATION

With the publication of MR 1-9 dated October 15, 1942, publication of AR 40-105 dated October 14, 1942, and publication of W.D. Circular Letter No. 126, 1942, there have been several changes in the dental standards for physical examination. The dental standards for physical examination for selectees and applicants for officer candidate schools will be in accordance with Section VII paragraphs 31, 32 and 33 of MR 1-9, dated October 15, 1942. The dental standards for temporary appointment to warrant officer will be the standard of final type physical examination that is required for commission in the Army of the United States (AR 40-105 dated October 14, 1942). The dental standards for appointment to warrant officer in the Regular Army will be those prescribed for appointment as commissioned officer in the Regular Army (AR 40-105 dated October 14, 1942). The dental standards for appointment to the United States Military Academy are unchanged. (AR 40-100 Sep. 10, 1940).

Following are extracts from the above mentioned publications for your information:-

War Department Circular No. 126, 1942.

(Amended: Sec. IV, Cir. 131; sec. III, Cir. 139; sec. VI, Cir. 153; sec. III, Cir. 156, 1942)

OFFICER CANDIDATE SCHOOLS. - 1. Rescission of previous instructions. Sections I and II, Circular No. 48, War Department, 1942, as amended by section VI, Circular No. 65; section II, Circular No. 75; section III, Circular No. 86; and section I, Circular No. 102, War Department, 1942, is rescinded. Provisions of MR 1-4, October 25, 1939, in conflict with instructions contained in this circular are modified as indicated.

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Qualification of Applicant.
(For Officer Candidate School)

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f. PHYSICAL.- (1) General. - The standard of final type physical examination will be that required for commission in the Army of the United States, except for height and teeth which will be the same as that for selectees.....

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Mobilization Regulations No. 1-9 * MR 1-9

War Department,
Washington, October 15, 1942

Standards of Physical Examination During Mobilization

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* This pamphlet supersedes MR 1-9, March 15, 1942, including section V, Circular No. 92, War Department, 1942.

1. PURPOSE. - a. The purpose of these regulations is to -
(1) Set forth the standards of physical requirements for men procured for general military service.
(2) Prescribe permissible deviations from the general service standards for limited military service.
(3) Describe deviations from the above standards which are not acceptable for any class of military service.

b. So far as it applies to enlisted men AR 40-105 is superseded by these regulations. These regulations will apply to men in the following categories:
(1) Men enlisted or reenlisted in the Regular Army.
(2) Men for enlistment or reenlistment in the Regular Army Reserve, Enlisted Reserve Corps, and Reservists on call to active service if they have been in the inactive Reserve longer than 90 days.
(3) Men enlisted or reenlisted in the National Guard while in Federal Service.
(4) Enlisted men of the National Guard on induction into Federal Service.
(5) Men enlisted in the Army of the United States.
(6) Men inducted into the Army under the provisions of the Selective Training and Service Act of 1940.

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Section VII.

Dental Requirements.

31. GENERAL SERVICE. - a. Individuals who are well nourished, of good musculature, are free from gross dental infections, and have a minimum requirement of an edentulous upper jaw and/or an edentulous lower jaw, corrected or correctible by a full denture or dentures.

b. Malocclusion. - When it is evident from the individual's general physical condition that his malocclusion has not seriously interfered with the mastication of a normal diet, provided that in the excursions of the mandible or with the mandible at rest, the teeth do not impinge upon opposing soft tissues and that the malocclusion has not resulted in secondary pathological changes.

32. LIMITED SERVICE. - There are no dental conditions that warrant classification as limited service.

33. NONACCEPTABLE. - Diseases of the jaws and associated structures which are irremediable or not easily remedied, or which are likely to incapacitate the individual for satisfactory performance of military duty.

b. Extensive loss of oral tissue in an amount that would prevent replacement of missing teeth by a satisfactory denture.

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* AR 40-105

Army Regulations
No. 40-1-5

War Department,
Washington, October 14, 1942.

Medical Department.

Standards of Physical examination for commission in Regular Army, National Guard of United States, Army of United States, and Organized Reserves.

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Section IX.
Teeth.

28. REQUIREMENTS FOR ACCEPTANCE. - No candidate will be accepted for appointment in the Regular Army unless he has a minimum of three serviceable natural masticating teeth above and three below opposing, and three serviceable natural incisors above and three below opposing. Therefore, the minimum requirement consists of a total of six masticating teeth and of six incisor teeth, all of which must be so opposed as to serve the purpose of incision and mastication. Applicants for commission in the Reserve components may be accepted if they meet the minimum requirements as outlined above or if the insufficient number of missing natural teeth are replaced by serviceable bridge work or dentures.

29. DEFINITIONS OF TERMS USED. - a. The term "masticating teeth" includes molar and bicuspid and the term "incisors" includes incisor and cuspid teeth.

b. The term "opposing" means serviceable opposing. Teeth that can be brought into good functional occlusion by the normal movements of the jaw may be considered as serviceably opposing.

c. A carious tooth which may be restored satisfactorily by proper fillings may be considered as "a serviceable natural tooth."

d. Teeth which have been satisfactorily restored by crowns or replaced by dummies attached to bridge work will be considered as "serviceable natural teeth" when the history and appearance clearly warrant such assumption.

e. A tooth is not to be considered "a serviceable natural tooth" when -

(1) It has extensive caries.
(2) It is involved with marked pyorrhea alveolaris.

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* This pamphlet supersedes AR 40-105, May 29, 1923, including C5, August 17, 1940; section 1, Circular No. 9, War Department, 1935; section IV, Circular No. 34, section III, Circular No. 95, paragraph 11, Circular No. 221, and section 1, Circular No. 229, War Department, 1941; and section III, Circular No. 6, War Department, 1942.

(3) It is the seat of chronic infection.
(4) It fails to enter into serviceable occlusion with the opposing tooth.

30. CONDITIONS WHICH ARE CAUSES FOR REJECTION. - a. Loss of teeth in excess of the standard noted in paragraph 28.

b. Marked pyorrhea alveolaris.

c. Gross irregularity which interferes with serviceable occlusion.

d. Marked protrusion or retrusion of either jaw.

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RUBBER LIGATURE BANDS.

Rubber bands for ligating fractures of the jaws, when continuous loop wiring is used, can be made from rubber tubing. The rubber tubing may be cut with a pair of scissors to any width of band desired. This tubing can be secured from the medical supply depots in various sizes, and the following item numbers are suggested:- 38760, 38780, and 44640.

ARMY NURSE CORPS SECTION.

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It is suggested that nurses obtain and read for their information Bulletin 63, War Department, December 31, 1942: "Pay and allowances of members of the Army Nurse Corps." This may be obtained from the Finance Officer.

With the change in status of the Army Nurse, an amendment to AR 40-20, Army Nurse Corps, saluting now becomes obligatory. It is recommended that all nurses read AR 600-25 in order to acquaint themselves with the rules governing this courtesy and to learn the proper technique.